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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08264

CERTIFICATE OF DEATH

08251

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARRIOTTSTVILLE</u>				c. LENGTH OF STAY IN 1b <u>13.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BON SECOURS PROVINCIAL HOUSE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER A POLLANAIRE BOLLORE</u>				4. DATE OF DEATH Month Day Year <u>JUNE 27 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 25, 1882</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FRANCE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>YVES BOLLORE</u>				14. MOTHER'S MAIDEN NAME <u>MARIE GOAT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Matthew Hunt Bon Secours Provincial</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>9 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>67</u> , to <u>June 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 27</u> , 19 <u>67</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert W. Lapp, M.D.</u>				22b. DATE SIGNED <u>6/29/67</u>		22c. PHYSICIAN'S NAME (Type) <u>HERBERT W. LAPP</u>	
22d. ADDRESS <u>4804 FREDERICK AVE</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-30-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Forley Cummings & Co. Catonsville, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUL 3 1967</u>							

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Charles Van der Grinten

John W. Ball

Buttman

Charles G. ...

CERTIFICATE OF DEATH

08265

08252

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Park</u>		c. LENGTH OF STAY IN lb <u>51 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Park</u> <u>13.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2019 Loudon Ave.</u>				d. STREET ADDRESS <u>2019 Loudon Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph A. Cooper</u> First Middle Last				4. DATE OF DEATH <u>June 15</u> 19 <u>67</u> Month Day Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 24, 1879</u>	9. AGE (In years lost birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Cooper</u> Address <u>2019 Loudon Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4221</u> IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO (b) <u>complications of Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>54 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>June 15, 1967</u> , that (I) (we) <u>lost</u> saw the deceased alive on <u>June 14, 1967</u> , and that death occurred at <u>6:30</u> M. from causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Brambaugh</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Bruce B. Brambaugh</u>				22d. ADDRESS <u>5609 Maine St. Ellicott City, Md 21227</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Ambrose, Inc. 1328 Sulphur Spring Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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08380

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CERTIFICATE OF DEATH

08266

08253

1. PLACE OF DEATH a. COUNTY <u>Harward</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>13.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>514 Grant Ave</u>		d. STREET ADDRESS <u>514 Grant Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Edwin</u>		4. DATE OF DEATH <u>June 20</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1915</u> 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>brewery</u>	9. AGE (In years last birthday) <u>50</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Peru West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Angus W Dane</u>		14. MOTHER'S MAIDEN NAME <u>Mary F. Simmans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>213 05 8322</u>	
17. INFORMANT <u>Auth Dane - Ahane</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Coronary Thrombosis</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> , 19 <u>67</u> to <u>6/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. M. Warren</u>		22d. ADDRESS <u>321 Prince Georges St. LAUREL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>	23d. LOCATION (City or Town) <u>Laurel</u> (County) <u>PG</u> (State) <u>MD</u>
24. FUNERAL DIRECTOR <u>De Witt Ransel</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 26 1967</u>	

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Use Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08267

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08254

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY c. LENGTH OF STAY IN lb 13-1		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cooksville	
3. NAME OF DECEASED (Type or print) PAUL Latham LAYTHROM		4. DATE OF DEATH Month June Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1924 43 yrs.
9. AGE (In years last birthday) Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME RICHARD LAYTHROM / Latham	
14. MOTHER'S MAIDEN NAME LOUISE GAINES		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 213-20-3795		17. INFORMANT Latham HELEN LAYTHROM Address ITEM #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by several cars	
20c. TIME OF INJURY Month, Day, Year Hour 10 p.m. 6/23 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Howard, Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		22. DATE SIGNED 6/24/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/28/67	23c. NAME OF CEMETERY OR CREMATORY BUSH PARK CEMETERY
23d. LOCATION (City or Town) (County) (State) COOKESVILLE, MD.		24. FUNERAL DIRECTOR ADDRESS ROCKVILLE, MD.	
25a. REC'D BY REGISTRAR JUN 29 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

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March 24, 1954

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FOR STATE
HEALTH DEPT.

08268

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08255

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY HOWARD County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Ellicott City Md		c. LENGTH OF STAY IN lb 5 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shaffer's Convalescent Retreat		d. STREET ADDRESS 16 Montgomery Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle TAYLOR Last		4. DATE OF DEATH Month June Day 21 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1883
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY schools	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Teacher George W. Taylor		14. MOTHER'S MAIDEN NAME Isabel Gisco	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 222-48-4331-7	
17. INFORMANT Shaffer Convales. Retreat Ellicott City Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 Hours 5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George E. Burgtorf M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George e. Burgtorf, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Ellicott City	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6-24-67	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR 6500 York Rd 21212	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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UNITED STATES
DEPARTMENT OF AGRICULTURE

WATER RESOURCES

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL JESSUP</u>		c. LENGTH OF STAY IN 1b <u>LIFELONG</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL JESSUP (SAVAGE)</u>		d. STREET ADDRESS <u>608 SAVAGE-GUILFORD ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>608 SAVAGE-GUILFORD ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CONRAD HENRY AUGUST VOLLMERHAUSEN</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 JULY 1903</u>
9. AGE (In years last birthday) yrs. <u>63</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING CONSTRUCTION</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HOWARD, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SEIBERT VOLLMERHAUSEN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH NICOLA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-09-7992</u>	
17. INFORMANT <u>SON</u>		Address <u>FRANK VOLLMERHAUSEN, JESSUP, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201 IMMEDIATE CAUSE (a) MYO CARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 1963</u> to <u>10 JUNE, 1967</u> , that (II) (we) last saw the deceased alive on <u>10 JUNE 1967</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard Compton</u>		22b. DATE SIGNED <u>10 June 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. RICHARD COMPTON, MD.</u>		22d. ADDRESS <u>612 MAIN ST., LAUREL, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>	23d. LOCATION (City or Town) (County) (State) <u>Heifers Corner Md</u>
24. FUNERAL DIRECTOR <u>W. W. Danaldson Laurel Md</u>		25a. REC'D BY REGISTRAR <u>JUN 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

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